Appendix 15
Drug Products Requiring Paper Submission For Prior Authorization Approval

Drug	Alitretinoin Gel
Approval Criteria	Indicated for the self-treatment of cutaneous lesions of acquired immune deficiency syndrome (AIDS)-related Kaposi's Sarcoma (KS).
Specific Requirements	Not indicated: • When systematic anti-Kaposi's Sarcoma therapy is required (more than 10 new lesions in the prior month). • In the presence of symptomatic lymphedema. • In the presence of symptomatic pulmonary KS. • In the presence of symptomatic visceral involvement.

Drug	Drugs That May Be Used for a Condition Other Than for the Treatment of Impotence
Approval Criteria	Indicated for use for a condition other than the treatment of impotence. Documentation must indicate the medical necessity of this product over any other product available for the treatment in question.
Specific Requirements	After March 1, 1997, Wisconsin Medicaid requires prior authorization (PA) for the following drugs: Alprostadil Systemic (Prostin VR Pediatric, Vasoprost), Phentolamine Systemic (Regitine), Phentolamine Oral (Vasomax).
Noncovered Diagnoses	After March 1, 1997, Wisconsin Medicaid does not cover the following impotence drugs: Alprostadil Intracavernosal (Caverject, Edex), Urethral Suppository (Muse), Phentolamine Intracavernosal (Regitine), Yohimbine, Sildenafil (Viagra). Wisconsin Medicaid denies PA requests for the above noncovered drugs.

Drug	Enteral Nutrition Products
Approval Criteria	See the "Approval Criteria" in **Appendix 16** of this section.
Specific Requirements	Bill dual Medicare/Medicaid recipient's claims for tube fed recipients first to Medicare. If the provider is unsure whether Medicare will pay for the claim, the provider is advised to obtain an approved Medicaid PA first before dispensing the service. If Medicare denies the claim, Wisconsin Medicaid may then reimburse back to the authorized PA date. • Complete the section of the PA drug attachment for enteral nutrition products. • Use HCFA Common Procedure Coding System (HCPCS) codes instead of National Drug Code codes and bill on the HCFA 1500 claim form. Refer to **Appendix 17** of this section for billing codes for enteral nutrition products.

Drug	Fertility Enhancing Drugs
Approval Criteria	Indicated for use for conditions other than the treatment of infertility. Documentation must indicate the medical necessity of this product over any other product available for the treatment in question.
Specific Requirements	Wisconsin Medicaid may approve these drugs only for treatments other than infertility.

Drug	Human Growth Hormone (Somatrem, Somatropin, Recombinant)	Human Growth Hormone Somatropin (rDNA origin) Serostim
Approval Criteria	Indicated for growth deficiency in children.	Indicated for the treatment for AIDS wasting or cachexia.
Specific Requirements	• The prescriber must be an endocrinologist or a pediatric endocrinologist. • The recipient's age must be 20 years or under. This criterion may be waived if the skeletal age is documented to be less than 18 years. • The results of growth stimulation testing must be a value of less than 12 nanograms/ml of growth hormone.	Refer to the questionnaire in **Appendix 17** of this section that must be completed by the prescribing physician.